TN 92-28 Approval Date JAN 25 1994
Supersedes TN 85-33 Effective Date NOV 1 - 1993

Revision: HCFA-PM-85-14 (DRRC)
SEPTEMBER 1985

OMB NO.: 0938-0193

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New York

The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)			X	$25 per recipient stay regardless of length of stay payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost less than $50. Therefore, the State will meet the requirements of 42 CFR 447.54(c)

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Ambulatory Services as follows:				The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims in accordance with 42 CFR 447.54 (a)(3)

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The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
Outpatient Hospital - including non-emergency or non-urgent medical services			X	$3
Diagnostic and Treatment Center (Free-standing clinics)			X	$3
X-Ray			X	$1 each procedure
Laboratory			X	$.50 each procedure
Medical/Sick Room Supplies			X	$1 each order

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STATE New York

A. The following changes are imposed on the categorically needy for services other than those provided under section 1905(n)(1) through (5) and (7) of the Act:

The Following charges are imposed on the medically needy for services:

SERVICE	TYPE OF CHARGE			AMOUNT AND BASIS FOR DETERMINATION
	DEDUCTABLE	COINSURANCE	COPAY	
Pharmacy				
1. Brand name drugs			X	$2.00
2. Generic drugs			X	$ .50
3. Non-prescription drugs			X	$ .50

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B. The method used to collect cost sharing charges for Medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient's own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.

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D. The procedures for implementing and enforcing the exclusions form cost sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social services districts.

MMIS Systems have been implemented to exclude certain groups of recipients form co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of $41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of $100 per Medicaid recipient will apply.

6.) Services provided by an HMO to an enrollee are identified via the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.

7.) No service provided by a hospice is subject to copay.Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from copay requirements.

8.) Additional exclusions from copayment may be made pursuant to state statute.